INSURANCE OPT OUT ELECTION – FOR METRO EMPLOYEES AND DISABILITY PENSIONERS

As a Metro Employee working 20 or more hours per week or a Disability Pensioner, the Metro Code requires you to be covered under Metro's medical and dental coverage unless you have **proof of other non-Medicare insurance coverage** (which may not include Medicare Advantage plans, Medicare Supplement plans, or Medicare A, B and/or D itself)**.** If your spouse, domestic partner or parent works for Metro, you may elect to be covered as a dependent on his/her medical and/or dental plan (you may only be covered on a parent's plan up to age 26, at which point you will be required to enroll in your own Metro coverage). If you and your spouse/domestic partner do not have dependent children, it will be cheaper to have two separate Single coverage plans.

You may opt out of Metro coverage at Annual Enrollment or within 60 days of an Eligible Change in Status with proof of other non-Medicare coverage. If you lose your other insurance coverage, you must notify Metro Human Resources and enroll in Metro coverage within 60 days.

ACKNOWLEDGEMENT: I understand that I am under an obligation to provide written documentation to Metro Human Resources within 60 calendar days of losing my other medical and/or dental coverage and that I must enroll in Metro's coverage within 60 calendar days. I understand that if I do not enroll at the time of an Eligible Change in Status, I may not enroll until the next Annual Enrollment. I further understand that if I fail to notify Metro Human Resources and do not enroll during this 60 calendar day period, I am violating the terms and conditions of my employment and exposing myself to considerable financial risk.

I elect to Opt Out of Metro's coverage as checked here: ☐ **MEDICAL** ☐ **DENTAL**
My other coverage ☐ **was** ☐ **was not** obtained through the Affordable Care Act's Marketplace Exchange.

My Spouse/Domestic Partner/Parent also works for Metro, and I am electing to be covered as a dependent on his/her ☐ MEDICAL and/or ☐ DENTAL plan(s). **Your spouse/domestic partner/parent must immediately contact Metro Human Resources to add you as a dependent to their plan.**

_____	_____	_____
Employee Printed Name	SSN or Employee #	Department
_____	_____	
Employee Signature	Date:	
_____	_____	
Spouse/Domestic Partner/Parent's Printed Name	Spouse/Domestic Partner/Parent's Department	
_____	Date: _____	_____
Metro HR Representative		Opt Out Effective Date

Updated 11/25/14